COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

Commission Minutes

Clarion Hotel
320 Hillsborough Street
Raleigh, NC 27603

Thursday, November 17, 2011

Attending:
John R. Corne, Dr. John S. Carbone, Debra Dihoff, Dr. Thomas Gettelman, Dr. John J. Haggerty, Matthew Harbin, A. Joseph Kaiser, Phillip A. Mooring, John Owen, Pamela Poteat, Don Trobaugh, David R. Turpin, Dr. James W. Finch, Beverly M. Morrow, Dr. Richard Brunstetter, Anna R. Cunningham, Frank Edwards, R. Michael Grannis, Dr. Greg Olley, Kevin Oliver

Excused Members:
Nancy Moore, Elizabeth Ramos, Jennifer Brobst

Other Absences:
Dr. Diana J. Antonacci, Dr. Ranota T. Hall

Division Staff:
Jim Jarrard, Steven Hairston, W. Denise Baker, Marta T. Hester, Andrea Borden, Dr. Beth Melcher, Amanda J. Reeder, Dr. Ureh Lekwauwa, William Bronson

Others:
Louise Fisher, Tara Fields, Stephanie Alexander, Deanna Janus, Bob Hedrick, Van W. Shaw, Ann Rodriquez

Call to Order:
John R. Corne, Chairman, NC Commission for Mental Health, Developmental Disabilities and Substance Abuse Services (Commission) called the meeting to order at 9:35 a.m. He asked for a moment of reflection and welcomed everyone to the meeting. Chairman Corne reviewed the ethics reminder and the ethics training requirements. He also advised that he has had no response from any of the Commission members regarding their desire to serve as the Chair of the Advisory Committee.

Approval of Minutes
Upon motion, second and unanimous vote, the Commission approved the minutes of the August 25, 2011 meeting.

Partnering for Success: The 1915(b)/(c) Medicaid Waiver – Initial DHHS Strategic Implementation Plan
Dr. Beth Melcher, NC Department of Health and Human Services (DHHS) Assistant Secretary for Mental Health, Developmental Disabilities and Substance Abuse Services (MH/DD/SAS), presented the report on the 1915(b)/(c) Medicaid Waiver. House Bill 916 required DHHS to: expand state-wide the 1915(b)/(c) waiver that is currently in operation at PBH; to submit a report to the General Assembly which specifies the timelines and a strategic implementation plan

outlining how DHHS will restructure the system within an 18 months timeframe; to report on the implementation process on a quarterly basis; and to include stakeholders in the development of the plan itself. To allow stakeholder input, the implementation plan was posted on the Division web site for a two week comment period; 63 pages of comments were received via this process. Dr. Melcher noted that the majority of the comments received were on the CAP-MR/DD waiver; those were forwarded to subject matter experts for review and response. Dr. Melcher discussed the plan's objectives as listed below.

- Objective 1: Oversee MH/DD/SA Service System Change
- Objective 2: Partner with LME-MCOs to Ensure Successful Implementation
- Objective 3: Ensure Access and Quality of the Service System for Individuals with MH/DD/SAS
- Objective 4: Strengthen the Partnership with Stakeholders in advising the State on Implementation of the Plan
- Objective 5: Increase Knowledge and Skills throughout the System
- Objective 6: Work with MCO's and CCNC to promote and implement a System of Integrated Care between MH/IDD/SAS Providers and Primary Care Providers

The plan is available at:
http://www.ncdhhs.gov/mhddsas/statspublications/Reports/reports-generalassembly/generalreports/2011/waiver1915b-cplan-final10-19-11.pdf.

Dr. Melcher indicated that a number of mechanisms have been established to ensure compliance with the plan's timelines and goals. For instance, each MCO will have an Intra-departmental Monitoring Team (IMT) which reviews its progress; DHHS will also be developing an Advisory Stakeholder group.

Dr. Melcher received the following questions and comments from the Commission:

- John Owen, Commission Member, asked if the purpose of the waiver was geared towards single stream funding and the removal of certain targeted funding streams. Dr. Melcher responded that it was not the single stream funding that currently exists but is a capitated system which pools all dollars together. The MCOs will now have the authority and tools to manage all of that money under a capitated system.
- Dr. John Haggerty, Commission Member, stated that he was still trying to understand what the partnership between the LMEs and the Community Care of North Carolina (CCNC) is going to look like, particularly regarding the flow of funds. Dr. Melcher stated there is an agreement between the LMEs and CCNC around the care coordination functions. CCNC's expertise is in the physical health arena while the LMEs expertise is in how to manage behavioral health needs.
- Dr. James Finch, Commission Member, stated that if the behavioral health codes are all within the management of the LME, it loses an opportunity to make use of personnel and expertise resources available through CCNC.
- Debra Dihoff, Commission Member, asked what money was included in the capitation and Dr. Melcher responded that state funds, federal funds, and Medicaid funds for the psychiatric billing codes are included.
- Anna R. Cunningham, Commission Member, asked Dr. Melcher to address the importance of data and information sharing and Dr. Melcher stated that HIPPA requirements are still in place.
- Don Trobaugh, Commission Member, asked about techniques, such as encryption, to secure client records. Jim Jarrard, Deputy Director, Division MH/DD/SAS, responded that the

personnel handling the encryption are absolutely committed to complying with all records maintenance and protection standards.

- Mr. Trobaugh asked if there was an independent caretaker (outside DHHS) to monitor and advise how the money is being spent. Dr. Melcher responded that there are multiple levels and part of the waiver requires several independent reviews. Jim Jarrard responded that the Department has two firms under contract to review the financial and fiscal integrity of the organization: Mercer and the External Quality Review Organization (EQRO).
- Dr. Thomas Gettelman, Commission Member, asked a question regarding the ability to continue to provide targeted case management under the waiver system. Dr. Gettelman stated that he believed that service was being eliminated once the site became a waiver site, which was confirmed by Dr. Melcher. Dr. Gettelman then stated that it seemed as though this would have a significant impact on the Critical Access Behavioral Health Agencies (CABHA) in those service sites. Dr. Gettelman stated that targeted case management brings in a lot of money; he wondered how the elimination of this service will impact the continued existence of many of the CABHAs and how this relates to access to services. Dr. Melcher responded that targeted case management does go away in the MCO world. Dr. Melcher stated that part of this was the need for the MCOs to have all the tools they need to be able to coordinate care. The Centers for Medicare and Medicaid Services (CMS) is not going to pay for care coordination twice, so there are various functions that are included in case management that should go over to the service or administration side. The decision has been made to place that responsibility on the administration side. Dr. Melcher stated that there are some things that the MCOs have the capacity to contract out. Dr. Melcher stated MCOs have been advised to offer contracts to all the providers endorsed in their areas for the first year to help ease the transition. However, over time, the MCOs will need to assess how many comprehensive care providers are actually needed in their respective areas.
- Beverly M. Morrow, Commission Member, asked if there is anything that PBH was doing that would not move forward to the other MCOs. Dr. Melcher responded that the intention of the NC General Assembly was not to have 11 different waivers; however, changes may be made over time depending upon need.
- Mr. Owen stated that one of his concerns regarding having only 11 MCOs is what, if any, mechanisms exist to replace them if they perform poorly. Dr. Melcher responded that ultimately the state is responsible to the federal government for the money it has received. She also stated that this is a contractual issue; if the MCOs are not performing and meeting their fiscal obligation the state has the capacity to transfer that contract to another MCO.

Division Director's Report

Jim Jarrard, Deputy Director, NC DMH/DD/SAS, provided the Director's Report. Mr. Jarrard addressed the adult care home questions posed to him at the August Commission meeting. The specific question centered on expectations of CMS and the Department of Justice (DOJ) as it relates to this issue. Mr. Jarrard stated that each requires different approaches. With CMS, it is more a matter of numbers, (i.e., how many people are in a given facility) while the DOJ is concerned about a much larger array of issues having to do with whether or not anyone with a mental health, development disabilities, or substance abuse diagnosis should reside in an adult care home. DHHS is now in the process of negotiating with them; it's not yet clear what the outcome of the negotiations will be.

Mr. Jarrard received the following questions and comments from the Commission:

- Mr. Owen stated that he was at the legislature and heard the presentation on how many people are improperly placed in adult care homes; he added that this is shocking from a budgetary standpoint.

- Ms. Cunningham asked how they can build community capacity to better meet the individual needs of the consumers who need appropriate supported housing. Mr. Jarrard stated that the operative term here is supported housing, which includes not just a place to live but a setting where one would reside successfully, which means that there are services for that individual who lives in that facility. Mr. Jarrard stated that this is what the DHHS and DOJ wants; however, it is extremely expensive.

Study and Report on Use of Pseudoephedrine Products to Make Methamphetamine

Mr. Van W. Shaw, Deputy Assistant Director, NC State Bureau of Investigation, Special Operations Division, NC Department of Justice (DOJ), gave a presentation on the use of pseudoephedrine products to make methamphetamine. Mr. Shaw provided an overview of methamphetamine labs throughout North Carolina, the problem that currently exists, and role that medications containing pseudoephdrine play in the process. He also discussed control mechanisms, how those are working, and how the DOJ is working to fight against this compounding problem.

S.L. 2011-240, HB 12, An Act to Increase the Regulation on Pseudoephedrine Products to Curtail Methamphetamine Production and to Reduce Costs to Local Governments for Lab Cleanup Costs, and to Study the Efficacy of Electronic Record Keeping with a Report to the 2013 General Assembly

Bill Bronson, Manager, Drug Control Unit, DMH/DD/SAS, gave the presentation on S.L. 2011-240. Mr. Bronson stated that it passed this past spring and mandated the use of the NPLEx system for reporting information into a national database. Mr. Bronson stated a person comes into the pharmacy and provides the same information that they had to provide under the current Methamphetamine prevention law, but the information is then entered by the pharmacy into the NPLEx system; the purchaser's photo identification is scanned into the system and the information is then reported to the national database. Mr. Bronson stated that the bill did not replace the current law, but added to the law. He further advised that he was coming before the Commission to ask them to approve the NPLEx reporting and the attestation as a form approved by the Commission, in order to avoid having pharmacies do double recordkeeping.

Upon motion, second and unanimous vote, the Commission approved adoption of the NPLEx System.

Update on Hospital Emergency Department (ED) Wait Times

Dr. Ureh Nena Lekwauwa, Chief, Clinical Policy, DMH/DD/SAS, gave the update on hospital Emergency Department (ED) wait times. Dr. Lekwauwa reminded the Commission that DHHS was mandated by the state legislature to do research evaluating the emergency department length of stay. Dr. Lekwauwa stated that data was collected from 68% of the hospitals in North Carolina (78 hospitals out of the 114). The results showed that 17.4% of ED visits are mental health related, 27.4% are substance abuse related, 0.4% is Developmental Disability (DD) related, and 1.9% unknown. The research also showed that, out of those waiting, 42.6% had other third party payer (e.g., private insurance, Medicaid, etc.). They also found that 32.3% are uninsured which accounts for one-third of the patients admitted. Dr. Lekwauwa stated that more than half of the individuals who presented in the ED went home with existing support, 7.5% went home with referrals to private mental health practitioners, and another 4.2% went home with a referral to their LMEs. Overall, there was an average wait time of 9.98 hours.

Dr. Lekwauwa received the following questions and comments from the Commission:

- Dr. Haggerty asked what is to happen next and Dr. Lekwauwa responded that the information will be sent to Secretary Cansler for his approval. At that point, DMH/DD/SAS will have to come up with specifics in terms of next steps, timelines, responsible persons, and priorities.
- Ms. Cunningham asked if similar statistics will be available following implementation of the MCOs. Dr. Lekwauwa responded that they have ED visit data every month for each hospital and will see if that data will change as the LMEs become MCOs.
- Dr. Richard Brunstetter, Commission Member, asked if she had any particular thoughts about children/adolescents in the ED rooms and how they may differ. Dr. Lekwauwa stated that one of the recommendations was to implement the children's facility based crisis service definition.
- Ms. Dihoff asked if there is something they can do better for the 50% who go home and if there are any protections to make sure that people do get medication or treatment. Dr. Lekwauwa responded that large EDs who are able to afford behavioral health specialists or psychiatrists can do an assessment and get patients started on medication. Dr. Lekwauwa also stated that they have to be flexible and they are not recommending that every community gets a facility based crisis. She concluded that unfortunately there is not one solution that fits all.

Proposed Amendment 10A NCAC 26E .0603 – Requirements for Transmission of Data

Amanda J. Reeder, Rulemaking Coordinator, Division Affairs Team, DMH/DD/SAS, gave the presentation on the amendment of 10A NCAC 26E .0603 – Requirements for Transmission of Data. Ms. Reeder stated that the proposed amendment had been approved by the Commission at its August 2011 meeting. This rule has gone through the 60 day comment period and was submitted to the Rules Review Commission (RRC) for approval. The rule was amended to change the reporting requirement timeframe in which to report to the Controlled Substance Reporting System (CSRS). The original Commission rule said the 1st and the 15th, but the law changed to seven days. The rule was amended only to comply with the new law. Ms. Reeder reminded the Commission that whenever you amend a rule it opens the entire rule for review by the RRC and they can address anything in the rule even if it is something that you have not changed. The RRC has asked for a technical change to this rule in (f)(2). They have asked that the Commission define or delete "undue". Upon recommendation from Bill Bronson, the Division has proposed a definition for 'undue", and asked the Commission to approve that amendment.

Upon motion, second and unanimous vote, the Commission approved the amendment to 10A NCAC 26E .0603 – Requirements for Transmission of Data for the RRC.

Prescription Drug Misuse

Bill Bronson gave the presentation to the Commission on prescription drug misuse and the controlled substances reporting system. Mr. Bronson stated that the entire issue of prescription drug abuse is a multi-dimensional group of problems that impact several systems and has overlapping populations. Mr. Bronson also stated that it is larger and more complex than it appears on the surface. He stated that the legislative intent for the Controlled Substance Reporting System was to improve the State's ability to identify controlled substance abusers or misusers and refer them for treatment, and to identify and stop diversion of prescription drugs in an efficient and cost-effective manner that will not impede the appropriate medical utilization of licit controlled substances.

Mr. Bronson received the following questions and comments from the Commission:

- Ms. Cunningham asked if the cancer or hospice patients were pulled out of the statistics that had been given on the opiates. Mr. Bronson responded that they had not, but that patients in a nursing home or hospital are not reported in the database.
- Dr. Finch stated that there are so many different angles to this problem and public awareness has to be one response and doctor education has to be another. Dr. Finch then asked what ways the Commission could help with this. Mr. Bronson responded that the first thing that they could do was talk to their own doctors about signing up to the CSRS, if they had not already done so, and to talk to friends and neighbors. Dr. Finch also stated that Mr. Bronson and anyone working with CSRS really did put together a system that has a clinical orientation as opposed to law enforcement focus.
- Chairman Corne asked what was the genesis on the special rules for substance abuse confidentiality. Mr. Bronson responded that the genesis was a federal treatment program in Lexington, Kentucky in 1974 that employed Drug Enforcement Agents as undercover agents in the treatment program. The patients who came into treatment bared their souls and talked about dealers, etc. As a result, the patients were being arrested the day that they were being discharged. Congress found out and wrote Title 42 of the Code of Federal Regulations as a reaction to that abuse of power.

In Ms. Brobst's absence, Chairman Corne addressed the status of the prison rules as it had been a major issue at the Rules Committee's October meeting; he asked Amanda Reeder to give an update. Ms. Reeder stated that the prison rules were at the Department of Corrections (DOC) and in the process of having a fiscal note completed. Ms. Reeder stated that DOC rulemaking coordinator performed an analysis of the rules and had several questions. Ms. Reeder was informed by the DOC rulemaking coordinator that the Division of Prisons, a Division within DOC, handles mental health within the prison system. The Division of Prisons has been given the questions and asked to provide answers to facilitate the fiscal analysis. Chairman Corne stated that the Rules Committee discussed and agreed to prepare a letter for the Commission Chair's signature urging DOC to expedite the preparation of the fiscal note. Chairman Corne asked if the members had any suggestions regarding the prison rules and also stated that the letter, if written, should be directed to the Secretary of DOC with the Governor's office perhaps copied on the letter. The Commission discussed sending a letter to Secretary Keller of DOC pointing out the delay in his Department completing the fiscal note and the issues regarding the care and maintenance of inmates with mental illness at the prison.

Public Comment

Louise Fisher, Volunteer Advocate for Mentally Ill Individuals, commented on the shortage of psychiatric beds in state hospitals.

Chairman Corne informed the Commission that today's meeting would be his last day serving on the Commission and the members thanked him for his service.

There being no further business, the meeting adjourned at 3:30 pm.